STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING _____ B. WING _____	C 01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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F 000	INITIAL COMMENTS Standard Survey Census: 90 Sample Size: 23 + 2 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		3/8/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/24/2023

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain a sanitary environment and ensure that equipment and furniture is clean and in good repair on 1 of 2 units, Unit A. This deficient practice was evidenced by the following: On 1/17/2023 9:47 AM, a tour of the Central Shower room located on "A" Wing, hallway 3 was conducted and the following was observed: A large yellow stain on the floor in the doorway of the Training Toilet room in the unit shower room. A discolored shower bed cushion containing multiple rips along the front edge. Two blue shower curtains that were hanging in the unit shower room containing multiple brown and black stains. Four rusty shower curtain rods were noted	F 584	1.) A random audit was conducted of residents on A-wing to determine if they were affected by the deficient practice of the rust on the shower rods, a stain on the floor, a discolored shower cushion, and 2 discolored shower curtains.The audit showed no residents were affected by the deficient practice. a. Housekeeping immediately mopped the floor to remove the stain, the cushion was thrown away, the shower curtains were replaced, the shower curtain rods had the rust removed with steel wool. b. The two chairs were removed from the unit and placed in the proper storage area for cleaning. 2.) Residents on A-wing have the potential to be affected by the deficient practice. On 2/9/23 the Housekeeping Director completed an audit of the shower rooms to ensure there were no stains, shower curtains were intact, and shower rods had no rust observed on them. 3.)To prevent the potential for	

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F 584	Continued From page 2 hanging up. On 1/19/2023 at 10:18 AM, on "A" Wing, hallway 2, two fabric chairs containing multiple stains were noted in the hall near Room 120. On 1/19/2023 at 10:37 AM, during an interview with the surveyor, the Director of Housekeeping (DOH) stated that the Central Shower room is cleaned every morning,the high touch areas such as the walls, shower knob, shower chairs/beds, and handrails are disinfected. The DOH further stated the floor is swept and mopped, and supplies are replaced as needed. On 1/19/2023 at 10:58 AM, two days after the initial observation of the Central Shower room located on A Wing, hallway 3, the surveyor conducted a tour with the DOH. All observations remained the same as noted above. During an interview with the surveyor at that time, the Director of Housekeeping stated, "yeah, that needs to be cleaned up," referring to the large yellow stain on the floor. The DOH went on to say that anything torn gets reported to maintenance, referring to the shower bed cushion. When asked, was the ripped chair cushion reported, the DOH stated, "no." The DOH confirmed that the two shower curtains contained multiple stains and stated, "they are to be replaced and that all four shower curtain rods contained rust need to be replaced. On 1/19/2023 at 11:07 AM, a tour of A Wing, hall 2 the DOH stated, while cleaning the floor, if we notice that the chairs are dirty, they are removed from the unit, then placed in the service hallway for cleaning. The DOH confirmed that the two chairs were soiled.	F 584	reoccurrence the Housekeeping Director educated all Housekeeping staff on job descriptions and cleaning policies to ensure the facility cleanliness. Director of Housekeeping or designee will conduct random resident audits of the overall facility cleanliness. During Resident Council meetings residents will be asked about the shower rooms, condition of furniture, and overall cleanliness of the facility. 4.) To maintain and monitor on-going compliance the Director of Housekeeping or designee will audit shower rooms 2x/week for 4 weeks and then monthly x 2. Findings will be corrected as needed. Results of these audits will be reviewed at QAPI meetings to ensure on-going compliance.	

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F 584	Continued From page 3 A review of the facility policy titled, "Housekeeping Procedure," undated, revealed, "Mattresses, mattress pads and covering, pillows, bedsprings, and other furnishings shall be properly maintained and kept clean and replaced as needed. They shall be thoroughly cleaned and disinfected on a regular schedule... All equipment and environmental surfaces shall be clean to sight and touch. All toilets and bathrooms shall be kept clean to sight and touch, in good repair, and free of odors. ...Porter Daily Duties and Responsibility...Shower Room Curtains..." N.J.A.C. 8:39-31.4(a)(c)(f)	F 584		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to follow a physician's ordered [redacted] scale when administering as needed [redacted] medication. This deficient practice was observed for 2 of 23 sampled resident's (Resident #76 and #73). This deficient practice was observed by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical	F 658	1.) Residents 76 and 73 received [redacted] medication that was given outside of parameters. MD was contacted and notified; orders were updated to include/clarify parameters. MD gave no new orders. 2.) All residents have the potential to be affected by the deficient practice. An audit was completed on all residents to ensure physician's order were reflective of PRN [redacted] medication orders. 3.)To prevent the potential for reoccurrence, education was completed	3/2/23

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F 658	Continued From page 4 nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions " b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem 1. On 1/13/2023 at 10:08 AM, during the initial tour of the facility, Licensed Practical Nurse (LPN #1) made the surveyor aware that Resident #76	F 658	with licensed nursing staff on ensuring physicians orders are followed and are reflective of the [redacted] scale. 4.) To maintain and monitor on-going compliance, the Director of Nursing or designee will audit sample residents daily x 7 days, weekly x 4, and monthly x6. Needed corrections will be addressed as they are discovered. Results will be reported to the QAPI committee for further review and recommendations.	

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may not talk with the surveyor and may become agitated and aggressive. The surveyor knocked on Resident #76's door however, at that time the resident declined to speak with the surveyor.

According to the Admission record Resident #76 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 [redacted]

A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 11/15/2022 revealed that Resident #76 had a Brief Interview for Mental Score (BIMS) of [redacted]/15, indicating that Resident #76 was EX Order 26 § 4b1. Section E of the MDS revealed that Resident #76 had no Ex.Order 26.4(b)(1) [redacted] Resident #76 was Ex.Order 26.4(b)(1) in all activities of daily living and section J revealed Resident #76 received scheduled [redacted] medication and EX Order 26 § 4b1 medication for almost EX Order 26 § 4b1 on a 1 to 10 scale EX Order 26 § 4b1 [redacted] According to Section N of the quarterly MDS, Resident #76 received an EX Order 26 § 4b1

A review of Resident #76's January 19, 2023, Order Summary Report revealed the following physician's order:

EX Order 26 § 4b1 [redacted] give (1) tablet by mouth every 6 hours as needed for EX Order 26 § 4b1

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A review of the 1/1/2023-1/31/2023 Medication Administration Record (MAR) for Resident #76 revealed that Resident #76 was administered EX Order 26 § 4b1 outside of the prescribed EX Order 26 § 4b1 [redacted].

A review of Resident #76's comprehensive care plan (documents developed by interdisciplinary care teams that contain specific, actionable information for clinicians and staff to promote communication and continuity of care by suggesting communications strategies and medical plans) revealed that resident #76 had a Focus: [resident name] exhibits alterations in EX Order 26 § 4b1 [redacted] Resident #76 had a care planned Goal, initiated on 8/17/2022 and revision on 11/16/2022 of [resident name] will achieve acceptable level of EX Order 26 § 4b1. The following was revealed under Interventions: Advise [resident name] to request EX Order medication before EX Order [redacted], date initiated: 8/17/2022 and revision on: 8/17/2022, and Monitor frequency of breakthrough EX Order to determine the need for EX Order

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[redacted], date initiated: 8/17/2022.

During an interview with the surveyor on n 1/18/2023 at 8:30 AM, Certified Nursing Assistant (CNA #2) assigned to Resident #76 for that shift, stated, [redacted]

Resident #76 refused to open their door to speak with surveyor at that time.

During an interview with the surveyor on 1/19/2023 at 11:10 AM, Registered Nurse (RN#1) assigned to Resident #76 for that shift was asked why the as needed [redacted] was administered to Resident #76 outside of the prescribed [redacted] scale for [redacted] RN#1 responded, [redacted]

The surveyor asked RN #1 if she would provide a [redacted] medication ordered for [redacted] when the resident verbalized a [redacted] level of less than 7. RN#1 responded, "If someone was a 5 on the [redacted] scale, I would give something like [redacted] but [resident name] threatens staff and becomes agitated and aggressive if he/she doesn't get what he/she wants. We're not supposed to give [redacted] for a [redacted] but he/she would become agitated and at times we would give the

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medication ([redacted]) if he/she wasn't a [redacted] on the [redacted] scale." RN#1 further explained that he/she rarely was ever less than a [redacted] on the [redacted] scale when assessed. I was always taught to honor what their verbalized [redacted] scale was because we cannot judge the resident's [redacted] The surveyor asked RN#1 if a [redacted] medication indicated and ordered for [redacted] should be provided outside of the [redacted] parameters per facility policy. RN#1 stated, "I do agree that the [redacted] should not be provided outside of the severe [redacted] scale parameters."

2. On 1/13/2023 at 10:12 AM, during the initial tour of the facility, Resident #73 refused to speak with the surveyor after surveyor identified themselves to the resident. Resident #73 stated, "I'm sleeping." On interview the assigned LPN#1 stated that Resident #73 was awake and alert and oriented and that he/she does attend [redacted] but refused to go today.

According to Resident #73's Admission Record, dated January 18, 2023, he/she was admitted to the facility with diagnoses including but not limited to: [redacted]

A review of Resident #73's comprehensive MDS, dated November 16, 2022, Resident #73 had a BIMS score of [redacted]/15, indicating [redacted]. Section G of the MDS revealed Resident #73 required [redacted] Section I indicated active diagnoses of [redacted]

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EX Order 26 § 4b1 Section J revealed that Resident #73 had EX Order 26 § 4b1 and that the EX Order was rated at EX on the EX Order 2 scale of 1 to 10. Section revealed Resident #73 received an EX Order 26 § 1 day of the 7-day assessment period.

A review of Resident #73's Order Summary Sheet revealed the following order:
EX Order 26 § 4b1 Give (1) tablet by mouth every 8 hours as needed for EX Order 26 § 4b1 -10, order date 11/09/2022.

A review of Resident #73's MAR dated 12/1/2022-12/31/2022 revealed the following: Resident #73 was administered
EX Order 26 § 4b1

A review of Resident #73's MAR dated 1/1/2023-1/31/2023 revealed the following: Resident #73 was administered
EX Order 26 § 4b1 -10, as ordered by the physician on the following dates: EX Order 26 § 4b1

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A review of Resident #73's comprehensive care plan revealed an active care plan under the heading Focus: [resident name] exhibits or is at risk for alterations in comfort related to acute EX Order, date initiated: 11/09/2022, revision date: 11/09/2022. The following was observed under the heading Interventions: EX Order 26 § 4b1 [redacted]

On 1/20/2023 at 1:09 PM, the surveyor conducted an interview with the facility Director of Nursing (DON), Licensed Nursing Home Administrator, Regional Administrator and Regional DON. When asked why nursing staff would provide an as needed EX Order medication for EX Order 26 § 4b1 (F-10) outside of the specified parameters the DON responded, "A nurse should not administer a severe EX Order medication outside the parameters for EX Order 26 § 4b1, as established by the facility policy."

On 1/23/2023 at 9:59 AM, during an interview the facility DON told the surveyor, "We acknowledge that we need to work on and document better that we have justification or work with the doctor for providing and documenting EX Order medication outside of our facility established parameters."

The surveyor reviewed the facility policy titles NSG227 EX Order 2 Management, review date 3/1/2022. The following was revealed under the heading PURPOSE: To maintain the highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate EX Order. The policy revealed the following under the heading Practice Standards: "When a patient asks for a EX Order 26 § 4b1 medication we must admister (sic) the EX Order medication based off what

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F 658	Continued From page 11 the patient states that they have a [EX Order 26 §] /10 they have to be medicated based off that order." NJAC 8:39-27.1(a)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Resident #11 Based on observations, interview, and record review it was determined that the facility failed to maintain respiratory equipment in a sanitary manner. This deficient practice was observed for 1 of 2 residents (Resident #11) surveyed for [EX Order 26 § 4b1]. The deficient practice was evidenced by the following: On 1/17/2023 at 9:05 AM the surveyor observed an [EX Order 26 § 4b1] in Resident #11's room. The [EX Order 26 § 4b1] and [EX Order 26 § 4b1] was observed to be dated but the surveyor was unable to read the label. The surveyor observed a [EX Order 26 § 4b1]	F 695	1.) Resident 11 was observed with [EX Order 26 § 4b1] on the floor and failure to follow a sanitary manner. The [EX Order 26 § 4b1] were immediately discarded and replaced and properly secured. 2.)All residents that are ordered/utilize [EX Order 26 § 4b1] have the potential to be affected. An audit was completed on all residents that utilize and are ordered [EX Order 26 § 4b1] to ensure [EX Order 26 §] is dated and equipment is secured in a sanitary manner. 3.) To prevent the reoccurrence, education was completed with licensed nursing staff on ensuring compliance with following maintaining [Ex.Order 26.4(b)(1)] in a sanitary manner. 4.) To maintain and monitor on-going compliance the Director of Nursing or	3/2/23

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F 695	Continued From page 12 mask on the resident's floor. The mask was not protected from contamination. According to Resident #11's Admission Record, Resident #11 was admitted to the facility with the following but not limited to diagnoses: EX Order 26 § 4b1 [redacted] A review of Resident #11's Order Listing Report, dated January 23, 2023, revealed that Resident #11 had the following and current physician orders: EX Order 26 § 4b1 [redacted] According to the Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, Resident #11 had a Brief Interview for Mental Status score of [redacted]/15, indicating [redacted] cognition. Section G of the MDS revealed Resident #11 required Ex.Order 26.4(b)(1) with all activities of daily living and Section O of the MDS revealed Resident #11 received [redacted] therapy. Review of Resident #11's comprehensive care plan revealed the following under Focus: [resident name] exhibits or is at EX Order 26 § 4b1	F 695	designee will audit sample residents daily x 7 days, weekly x 4, and monthly x 6. Needed corrections will be addressed as they are discovered. Results will be reported to the QAPI committee for further review and recommendations.	

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	315508	A. BUILDING _____ B. WING _____	C 01/30/2023

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complications related to EX Order 26 § 4b1 [redacted] date initiated: 01/03/2023. The following was listed under Interventions: Instruct resident in use and encourage EX Order 26 § 4b1 [redacted]

According to the 1/1/2023-1/31/2023 Medication Administration Record (MAR) Resident #11 received EX Order 26 § 4b1 [redacted].

On 1/18/2023 at 8:41 AM the surveyor observed Resident #11 sitting in his/her EX Order 26 § 4b1 eating breakfast. The EX Order 26 § 4b1 was attached to the EX Order 26 § 4b concentrator and was dated "1/18 1 AM." The EX Order 26 § 4b tubing was resting on the top of the EX Order 26 § 4b concentrator and was exposed. The EX Order 26 § 4b1 was on top of the bedside table and was unprotected and in contact with the table surface.

On 1/19/2023 at 9:08 AM the surveyor observed Resident #11 in their room seated in their EX Order 26 § 4b1. The EX Order 26 § 4b1 was powered on and observed to be set at EX Order 26 § 4b The EX Order 26 § 4b1 was hanging in front of the control panel and was not covered, leaving it exposed. The EX Order 26 § 4b1 was on the bedside table as previously observed on the 1/18/2023 observation and was covered with a clear EX Order 26 § bag. The surveyor asked Resident #11 when he/she had last used his/her EX Order 26 § 4b. Resident #11 stated that he/she had not used the EX Order 26 § 4b

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F 695	Continued From page 14 since yesterday. Resident #11 further stated, "Is it on, I don't know how to shut it off anyway." On 1/19/2023 at 9:39 AM the surveyor interviewed the Registered Nurse (RN) assigned to Resident #11 for that shift. The surveyor had the RN come to Resident #11's room and asked the RN to observe the EX Order 26 § 4b1 [redacted]. The RN replied, "The EX Order 26 § 4b1 should be bagged when not in use, the EX Order 26 [redacted], right? The EX Order 26 § 4b1 should be bagged when not in use. I'm not sure if he/she was using it today. The RN further stated, "I know he/she had it on last night." On 1/20/2023 at 01:18 PM during an interview with the facility administration the facility Director of Nursing (DON) stated the following: "We bag the EX Order 26 § 4b1 when it is not in use. That is our practice, that is also the same practice for the EX Order 26 § 4b1 ."	F 695		
F 761 SS=D	NJAC 8:39-25.2 (3) and 27.1 (a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		3/2/23

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F 761	Continued From page 15 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation it was determined that the facility failed to 1.) date medication when opened and stored for continued use as well as failed to dispose of expired medications and 2.) failed to properly store a respiratory medication according to facility policy. This deficient practice was identified for 1 of 2 medication storage rooms (A wing) and 1 of 2 residents (Resident #11) surveyed for EX Order 26 § 4b1. This deficient practice was evidenced by the following: 1. On 1/17/2023 at 8:34 AM, the surveyor reviewed the locked Medication room on A wing with the Licensed Practical Nurse/Unit Manager (LPN/UM). In the locked Medication Refrigerator, the following was observed: 1. Influenza vaccine 5 ml (milliliter) multi dose vial in a broken box dated 12/14/22. The vial was undated, and the LPN/UM said the vial is good for 28 days after it was opened.	F 761	1.) No residents were affected by the deficient practice due to no medications were administered. The expired medications in the locked medication refrigerator on A-wing were immediately disposed of appropriately. a. Resident 11 was observed with failure to have Ex.Order 26.4(b)(1) medication properly stored. Ex.Order 26.4(b)(1) medication was removed from bedside and placed appropriately in the medication cart. 2.) a.All residents have the potential to be affected by the deficient practice. An audit was completed on all medications in medication carts and medication refrigerators and ensured within the expiration date and labeled appropriately. b. All residents that have Ex.Order 26.4(b)(1) medications have the potential to be affected by the deficient practice. An audit was completed on all residents with Ex.Order 26.4(b)(1) medications to ensure compliance of medications storage. 3.) To prevent the potential for	

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F 761	Continued From page 16 2. Lispro Insulin 100/ml opened and undated. It was contained in a hard plastic bottle with a lid. At 8:38 AM LPN/UM said when the vial is opened, we date it with the sticker that pharmacy supplies with the medication and then it is good for 28 days. The LPN/UM shook the plastic bottle and the sticker fell out of the bottle and was not filled out. LPN/UM confirmed the vial was undated and should have been dated. 3. A Bottle of Tamiflu liquid 30 mg (milligram)/5 ml. The bottle had a yellow label on which it was handwritten to "Discard unused portion of the medicine after 12/7/22." On 1/17/2023 at 8:41 AM, the LPN/UM confirmed the medications were expired and that the insulin was not dated. During an interview with the surveyor on 1/20/2023 at 1:04 PM, the Director of Nursing said absolutely that the expired medications should have been pulled from the medication refrigerator. 2. On 1/17/2023 at 9:05 AM the surveyor observed an EX Order 26 § 4b1 [redacted] in Resident #11's room. The [redacted] was observed to be dated but the surveyor was unable to read the label. The surveyor observed a EX Order 26 § 4b1 on the resident's floor and in contact with floor. The surveyor also observed what was identified by the resident as an Ex.Order 26.4(b)(1) on the bedside table. Resident #11 stated, "It's for emergencies."	F 761	reoccurrence, education was completed with licensed nursing staff on ensuring compliance with following appropriate Ex.Order 26.4(b)(1) medication storage, dating medications upon opening,and disposal of expired medications. 4.) To maintain and monitor on-going compliance the Director of Nursing or designee will audit the medication refrigerators for compliance with dating of open medications,and storage of Ex.Order 26.4(b)(1) medications daily x 7 days, weekly x4, and monthly x6. Needed corrections will be addressed as they as discovered. Results will be reported to the monthly QAPI committee for further review and recommendations.	

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F 761	Continued From page 17 According to Resident #11's Admission Record Resident #11 was admitted to the facility with the following but not limited to diagnoses: EX Order 26 § 4b1 [redacted] A review of Resident #11's Order Listing Report dated January 23, 2023, Resident #11 had the following physician orders: EX Order 26 § 4b1 [redacted] According to the Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, Resident #11 had a Brief Interview for Mental Status score of [redacted]/15, EX Order 26 § 4b1 [redacted]. Section G of the MDS revealed Resident #11 required Ex.Order 26.4(b)(1) [redacted] with all activities of daily living and Section O of the MDS revealed Resident #11 received EX Order 26 § 4b [redacted]. According to the 1/1/2023-1/31/2023 Medication Administration Record (MAR) resident #11 received EX Order 26 § 4b1 [redacted]	F 761		

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F 761	Continued From page 18 On 1/18/23 at 8:41 AM the surveyor observed Resident #11 sitting in his/her [redacted] eating breakfast. An [redacted] was on top of the bedside table. On 1/19/23 at 9:08 AM the surveyor observed Resident #11 in their room seated in their [redacted]. The [redacted] was observed to be on the bedside table as previously observed on 1/18/2023. On 1/19/2023 at 9:39 AM the surveyor interviewed the Registered Nurse (RN) assigned to Resident #11 for that shift. The surveyor had the RN come to Resident #11's room and observed the asked to observe the [redacted] When asked if the [redacted] should be left at the bedside and not stored in the medication cart the RN responded, "[redacted] A review of Resident #11's comprehensive care plan revealed that there was no care plan initiated for the self-administration of [redacted]. On 1/20/2023 at 01:18 PM during an interview with the facility administration the facility Director of Nursing (DON) stated the following when asked if [redacted] were allowed to be kept in the residents' room, "I would have to look up if we have any residents that self-administer medications. It is our facility practice that prescribed [redacted] are to be locked in the medication carts when not being used. They should not be left in the resident's room." The facility provided a policy for	F 761		

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F 761	Continued From page 19 self-administering medications; however, it was deemed that Resident #11 was not on a self-administering program at the time and there was no care plan or assessment completed for self-administering medications EX Order 26 § 4b1 with Resident #11. The surveyor reviewed the facility policy titled 6.0 Medication Storage, Revised: September 2020. The following was revealed under the heading PROCEDURE: A. With the exception of Emergency Drug Kits and medications requiring refrigeration, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy. F. Expired, discontinued and/or contaminated medications will be removed form [sic] (from) the medication storage areas and disposed of in accordance with facility policy.	F 761		
F 812 SS=E	NJAC 8:39-29.4(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		3/2/23

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F 812	Continued From page 20 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 1/13/2023 from 9:11 AM to 9:47 AM, the surveyor accompanied by the Cook, observed the following in the kitchen: 1. Upon entry to the kitchen the surveyor observed a female dietary aide (DA) without a hairnet. The DA had lengthy hair that extended to the shoulder area and was in a ponytail and exposed. 2. In the dry storage room an opened box of chicken soup base was on top of a wheeled cart near the door. The box contained a plastic bag of yellow soup base that was exposed to the air. When interviewed the cook stated, "It should be closed and not exposed to the air." On a middle shelf of a multi-tiered shelf, a 25-pound bag of rice was opened and exposed. On interview the cook agreed it should be sealed to prevent contamination.	F 812	1.) No residents were affected by the deficient practice of food safety requirements. a. All dietary staff were directed to comply with wearing hair nets to ensure kitchen sanitation is maintained. b. The dry open box of chicken soup base was changed so there is a permanent sliding lid on the container. The open bags of chicken flavor soup base and rice were discarded. c. The dented can of pears was immediately removed. They were placed in the appropriate area labeled dented cans to be discarded per procedure. d. An annual temperature log was created and is on the temperature log clipboard so there is access for the log every month. e. The beverages that were not labeled were disposed of immediately. f. The hot dogs were immediately discarded. g. The white Styrofoam container was disposed of, as well as the apple pie. A new keypad lock was installed on the pantry door that will allow only staff to store food in the refrigerator to ensure proper labeling and dating.	

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F 812	Continued From page 21 3. A can of diced pears was observed on a middle rack on a wheeled can storage cart. The can had a significant dent on the side in the middle of the can. 4. A review of Walk-In Refrigerator temperature log for January 2023 revealed no temperatures were taken in the AM/PM for the walk-in refrigerator. The Cook stated that all staff share in recording refrigeration temperatures, and it depends on who is here in the morning and at night. Further review of the refrigeration temperature log revealed that no temperatures were recorded for refrigerators or freezers on January 1, January 2, and January 3 of 2023. 5. In the walk-in refrigerator on a middle shelf (2) trays stacked on top of each other contained plastic beverage cups filled with an orange/yellow liquid and covered with plastic lids. The beverages had no dates. 6. On an upper shelf in the cook's refrigerator box a package of opened hot dogs were wrapped in plastic wrap. The hot dogs had no dates. On 1/18/2023 from 8:47 AM to 8:55 AM, the surveyor accompanied by the Registered Nurse (RN) observed the following in the A-Wing pantry: 1. On a shelf in the pantry refrigerator, a white Styrofoam take out style container in a clear plastic bag was labeled with a room number and had no date, as required per facility policy. In addition, what appeared to be a piece of apple pie covered with plastic wrap also was labeled with a room number and was not dated. According to the RN, "The food should be dated and thrown away after 72 hours. The nursing staff is	F 812	h. On 1/20/23 the surveyor observed in the dry storage room a cardboard box labeled chicken flavor soup base on top of a wheeled cart. The box was opened and inside a plastic bag of chicken soup base was opened and exposed. The chicken flavor soup base was disposed of and a new container with a permanent closing lid is now being used. 2.) All residents have the potential to be affected by the deficient practice. On 2/9/23 the Food Service Director completed an audit of dietary staff to ensure hair nets were in place. An audit of the dry storage area to ensure there were no open bags to prevent contamination and no dented cans. Review of walk in temperature log completed to ensure log completed and refrigerator temperatures remain within required temperatures. Walk-in refrigerator was audited to ensure there were no items without a date and name in the pantry area. 3.)To prevent the potential for reoccurrence the Food Service Director completed education with dietary staff to ensure proper food labeling and dating of all items, dented cans are not placed on the food shelves and placed in area labeled as dented cans and are discarded as appropriate, annual temperature logs are maintained as required with appropriate temperature. 4.) To maintain and monitor on-going compliance the Food Service Director or designee will monitor pantries, refrigerator temperatures, labeling and dating to ensure all items are properly labeled are dated. Audits will be conducted weekly for	

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F 812	Continued From page 22 responsible for monitoring food brought in by the residents family." On 1/20/2023 from 11:15 AM to 12:04 PM, the surveyor, accompanied by the Food Service Director (FSD) observed the following in the kitchen: 1. In the dry storage room a cardboard box labeled chicken flavor soup base was on top of a wheeled cart. The box was opened and inside a plastic bag of chicken soup base was opened and exposed. The surveyor reviewed the facility policy titled Infection Control, undated. The following was revealed under the heading FOOD HANDLING: 1. Never use any item, which has been exposed, to an unsanitary area, such as the floor. a. Food, which is suspected of being contaminated, is not served. 2. Can foods that are swollen, dented, rusted, or that bulge, or leak are returned to the purveyor. These cans are stored in the food storeroom in a section labeled "DENTED CANS". They are not to be used under any circumstances. The policy revealed the following under the heading FOOD STORAGE: 2. All food must be covered, labeled, and dated before storage. 3. Refrigerator temperatures must be 45 F (Fahrenheit) or below. Freezer temperatures must be 0 F or below. Keep doors closed tightly. Report temperatures above the safe zone to your	F 812	x 4 and monthly thereafter. Results of these audits will be reviewed at the monthly QAPI meetings to ensure on-going compliance.	

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F 812	Continued From page 23 supervisor. The policy also reflected the following: **HAIRNETS/BEARD GUARDS MUST BE WORN AT ALL TIMES** The surveyor reviewed the facility titled [facility name]. The policy revealed the following under the heading Procedure: 3. Resident and or person bringing in the food will be notified that perishable food will only be kept for 24 hours. All non-perishable food will be kept for 72 hours. 5. Nursing staff will monitor resident's room, unit pantry, and refrigeration units for food and beverage disposal. NJAC 8:39-17.2(g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		3/2/23

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F 880	Continued From page 24 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING _____ B. WING _____	C 01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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F 880	Continued From page 25 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to ensure personal protective equipment (PPE) (equipment such as, but not limited to gowns, gloves, and eye protection worn to protect the wearer from the spread of infection or illness) was used appropriately when entering resident rooms that were under precautions for COVID-19 (a potentially deadly respiratory virus). This deficient practice was evidenced by the following: On 1/13/2023 at 10:34 AM, during the initial tour of the facility, the surveyor observed room Ex.Order on A Wing. Room Ex.Order was within the facility designated "Yellow Zone" as shown on the facility provided floorplan. Outside of the room was a bin containing gowns, gloves, and masks. There were no signs or notifications on the door or in the doorway. Inside of room Ex.Order was a staff member, later identified as the Speech Language Therapist (SLT) sitting down adjacent to Resident #339. The SLT did not have a gown on while sitting with the resident.	F 880	1.)A staff member, (Speech Therapist) entered the room Ex.Order where resident 339 was residing. The employee did not wear appropriate personal protective equipment in a designated "yellow zone" room. The appropriate sign was placed on the door of room Ex.Order. The staff member was immediately educated on the PPE process and signage. Upon further review, the referring hospital was contacted and we received documentation that indicated resident 339 was in fact, Ex.Order 26.4(b)(1) and did not require a "yellow zone" room. 2.) All residents have the potential to be affected. An audit was of all residents to ensure physician's order were reflective of isolation status and/or Ex.Order 26.4(b) diagnosis in the medical record. 3.) To prevent the potential for reoccurrence, education will be conducted by the Director of Nursing or designee for all staff to ensure proper PPE is used when entering resident rooms which are under precautions for Ex.Order 26.4(b)(1) 4.) To maintain and monitor on-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 26 On the same date at 10:41 AM, during an interview with the surveyor, the SLT confirmed she was in room [redacted] with Resident #339. She said she had no knowledge she was to wear a gown inside that room. On the same date at 11:55 AM, the surveyor observed a blue sign titled, "Enhanced Droplet Precautions." placed on the door of room [redacted]. The sign revealed, "Wear an N95/approved HN95 Respirator, Gown, Face Shield, and Gloves upon entering this room..." On the same date at 12:01 PM, during an interview with the surveyor, the Infection Prevention/Licensed Practical Nurse (IP/LPN) confirmed that a gown must be worn in room [redacted]. During the same interview, the Director of Nursing stated that the Unit Manager removed the sign from room [redacted] because she thought the resident no longer required precautions. On the same date at 12:42 PM, during an interview with the surveyor, the Certified Nursing Assistant (CNA #1) stated, "Signs were up this morning. They came down and now are back up." On 1/18/2023 at 1:12 PM, during an interview with the surveyor, the IP/LPN stated that residents within the "Yellow Zone" are any new admissions who come to the facility unvaccinated or without documentation of vaccination for COVID-19. Further, she said they are isolated in their room and anyone entering the room needs full PPE which includes a gown, gloves, and goggles. On 1/20/2023 at 1:01 PM, during an interview	F 880	compliance the Director of Nursing or designee will audit infection control tier level precautions (standard or transmission based) of all new admissions and residents. Audit will be conducted daily for 1 week, 1 time a week for 1 month, and thereafter 1 time a month for 6 months. Needed corrections will be addressed as they are discovered. Results will be reported to the QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING _____ B. WING _____	C 01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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F 880	Continued From page 27 with the surveyor, the Director of Nursing confirmed that staff should be wearing gowns in rooms that are in the "Yellow Zone." A review of an undated facility policy titled, "Infection Control Precautions for COVID19" revealed, "All employees, health care workers and visitors who enter the room of a resident with confirmed or suspected COVID 19 must adhere to Standard, Contact and Droplet/Contact precautions including the use of eye protection." N.J.A.C. 8:39-19.4(a)	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to adequately monitor the use of an Ex.Order 26.4(b)(1) by administering 13 of the prescribed 14 doses. The deficient practice was identified for 1 of 5 residents (Resident #47) reviewed for Unnecessary Medications. This deficient practice was evidenced by the following:	F 881	1.) Resident #47 was administered 13 out of ordered 14 doses of Ex.Order 26.4(b)(1) [redacted] MD notified and orders updated to include and clarify duration, with no harm noted for the resident. 2.) All residents on Ex.Order 2[redacted] have the potential to be affected by the deficient practice. An audit was completed of all current residents on Ex.Order 2[redacted] to ensure physician's ordered dosing duration of Ex.Order [redacted] are completed as ordered.	3/2/23

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	315508	A. BUILDING _____ B. WING _____	C 01/30/2023

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PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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F 881	Continued From page 28 A review of Resident #47's physician orders located in the electronic medical record revealed that he/she was prescribed EX Order 26 § 4b1 [redacted] to be given twice a day for seven days. The Ex.Order 26.4(b)([redacted] administration started on January 12, 2023, at 9:00 PM. A review of Resident #47's January 2023 Medication Administration Record revealed that on January 13, no dose of EX Order 26 § 4b1 was given at 9:00 AM. On 1/20/2023 at 9:12 AM, during an interview with the surveyor, the Unit Manager/Licensed Practical Nurse (UMLPN #1) confirmed a Ex.Order 26.4(b)(dose was not administered on January 13 at 9:00 AM. On interview LPN/UM#1 stated "I could not tell you" when asked if there was a reason Resident #47 did not receive a dose of EX Order 26 § 4b [redacted] on January 13 at 9:00 AM. On 1/23/2023 at 9:48 AM, during an interview with the surveyor, the Director of Nursing confirmed that a dose of Ex.Order 26.4(b)(was not given on January 13 at 9:00 AM. The facility was unable to provide a policy regarding the Ex.Order 26,4(b)(1) administration. NJAC 8:39-29.2(d)	F 881	3.) To prevent the potential for reoccurrence, education was completed with licensed nursing staff on ensuring compliance with Ex.Order 26 [redacted] order creation, MD notification of missed doses and documentation of incomplete Ex.Order 2 [redacted] as ordered by the MD. 4.) To maintain and monitor on-going compliance the Director of Nursing or designee will audit all residents on Ex.Order 2 [redacted] of all new admissions and residents. An audit will be conducted daily x 7 days, weekly x4, then monthly x6. Needed corrections will be addressed as they are discovered. Results will be reported to the QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05001	A. BUILDING: _____ B. WING _____	C 01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to: a) Maintain a record of influenza vaccinations for all facility employees, per diem and contract employees as required for compliance with N.J.S.A 26:2H-18.79- Influenza vaccination in health care facilities and b) maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident on 5 of 14 day shifts, in total staff for residents on 1 of 14 evening shifts and in CNAs (Certified Nursing Assistants) to total staff on 1 of 14 evening shifts. Findings include: 1. Reference: On January 13, 2020, Governor Murphy signed P.L. 2019 c. 330 (codified at	S 560	1.) No residents were affected by the deficient practice of facility failing to obtain influenza vaccination proof of per diem and contracted employees. a.Influenza vaccination verifications for all per diem and contracted employees were obtained and maintained on file. The state mandated information was provided to per diem and contracted employees. We immediately started screening all per diem and contracted employees to verify they had the influenza vaccine. If they were not able to provide proof of vaccination they were not permitted in the facility. b.Staffing ratio was not met on 5/14 day shifts. Contacted local agencies and held a job fair to obtain more staff. Also,	3/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/24/23

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S 560	Continued From page 1 N.J.S.A. 26:2H-18.79 and referred to hereafter as "the Statute"). The Statute requires certain healthcare facilities to establish and implement an annual influenza vaccination program. The New Jersey Department of Health (Department) is required by the Statute to promulgate rules and designate a medical exemption form to be distributed to the covered healthcare facilities. This memo and the attached form are intended to assist general or special hospitals, nursing homes (long-term care facilities licensed pursuant to N.J.A.C. 8:39), and home health care agencies, collectively referred to as "facility" or "facilities," in understanding and meeting their obligations under the Statute, until the rules and the medical exemption form can be adopted through rulemaking. Covered Employees All facility employees are required to be vaccinated, including employees who are not responsible for direct patient care. Per diem and contract employees are to be considered facility employees and are required to be vaccinated. Record Keeping Facilities must maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee. The Department will address through rulemaking proper procedures for submitting data to the Department. During entrance conference on 1/13/2023, the surveyor requested a list of all staff documentation for the 2022-2023 Influenza season. A review of the facility provided document that indicated staff flu vaccine status, did not include	S 560	conducted a salary survey and increased our CNA rates. The staff scheduler was educated on maintaining the state required staff to resident ratio. 2.)All residents have the potential to be affected. a. An audit was completed of all per diem or contracted employees to have the annual influenza vaccine on file. b. Administrator completed an audit from survey exit to present of staffing ratio to ensure the staffing ratios have been met. 3.) a. To prevent the potential for reoccurrence, education was completed with the Infection Control Preventionist and the receptionists on the state mandate for influenza vaccines to be logged for all per diem or contracted employees and vendors. b. To prevent the potential or reoccurrence, education was completed by the Administrator for the staff scheduler on ensuring the appropriate staffing ratios are met. 4.) a.To maintain and monitor on-going compliance the ICP or designee will audit sample vendors or contracted employees twice a week for 4 weeks and then monthly x2 to ensure compliance. Needed corrections will be addressed as they are discovered. Results will be reported to QAPI committee for further review and recommendations. b. To maintain and monitor on-going compliance the Administrator or designee will audit schedules for 4 weeks then monthly x2 to ensure compliance. Needed corrections will be addressed as they are discovered. Results will be reported to the monthly QAPI committee for further review	

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S 560	Continued From page 2 facility contracted staff influenza vaccine status. During an interview with the surveyor on 1/19/2023 at 12:51 PM, the Director of Nursing (DON) she stated that they failed to maintain records of influenza vaccinations for outside vendors. During a meeting with the facility Administration on 1/23/2023 at 9:48 AM, the DON admitted that they did not have influenza vaccination records for vendors. A review of an undated facility policy titled "Influenza Vaccine" included, under "Surveillance Data" #8, "The Infection Preventionist will maintain surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff. Surveillance data will be made available to staff as part of the educational efforts to improve vaccination rates among employees." 2. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight	S 560	and recommendations.	

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S 560	Continued From page 3	S 560		

residents for the day shift.

One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and

One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.

As per the "Nursing Staffing Report" completed by the facility for the weeks of 12/25/2022 and 1/1/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows:

-12/25/22 had 10 CNAs for 85 residents on the day shift, required 11 CNAs.
-12/26/22 had 10 CNAs for 85 residents on the day shift, required 11 CNAs.
-12/29/22 had 10 CNAs for 85 residents on the day shift, required 11 CNAs.
-12/30/22 had 10 CNAs for 85 residents on the day shift, required 11 CNAs.
-01/01/23 had 5 total staff for 83 residents on the evening shift, required 8 total staff.
-01/01/23 had 0 CNAs to 5 total staff on the evening shift, required 2 CNAs.
-01/07/23 had 10 CNAs for 89 residents on the day shift, required 11 CNAs.

On 1/19/23 at 11:28 AM during an interview with the surveyor, the Staffing Coordinator replied, "yes." when asked, if the facility was aware of the

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S 560	Continued From page 4 mandated staffing requirements. When asked if the facility was meeting the mandated requirements the Staffing Coordinator replied, "We are meeting the requirements some days. There has been some days that are challenging but for the most part, we are." On 1/20/23 at 01:34 PM during an interview with the surveyor, the DON and Regional DON replied, "yes." when asked if the facility was aware of the mandated staffing requirements. The DON replied, "yes." when asked if the facility was meeting the mandated requirements. The facility was unable to provide a policy regarding the minimum staffing requirements.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315508 Y1	A. Building B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0658	Correction	ID Prefix F0695	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed
LSC	03/08/2023	LSC	03/02/2023	LSC	03/02/2023
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	03/02/2023	LSC	03/02/2023	LSC	03/02/2023
ID Prefix F0881	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/02/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
05001 Y1	A. Building B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/02/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING **01** B. WING _____	C **01/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	**3809 BAYSHORE ROAD** **NORTH CAPE MAY, NJ 08204**

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/30/23. The facility was found to not be in compliance with 42 CFR 483.73. .	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.	E 041		3/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2023

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E 041	Continued From page 1 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a	E 041		

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E 041	Continued From page 2 document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to ensure the emergency preparedness policy plan addressed how the facility would maintain generator power/fuel during an emergency. This deficient practice could affect all 94 residents. A review of the facility Emergency Preparedness policy revealed the facility policy lacked a	E 041	1.) No residents were affected by the deficient practice. 2.) There were 94 residents that had the potential to be affected by the deficient practice. 3.) We contracted with a fuel company that will supply emergency fuel for our generator to maintain operation power systems during an emergency. The facility's Emergency Preparedness Plan	

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E 041	Continued From page 3 reference to a plan to maintain operational power systems during an emergency. An interview with the Maintenance Director and Administrator on 01/30/23 at 3:30 PM verified the facility lacked a plan to maintain fuel sources for emergency power during an emergency. NJAC 8:39-31.2(e) NFPA 99, 110 .	E 041	was updated to include this information. Education was provided to the Director of Maintenance on the need for a back-up fuel provider. Facility will always maintain a back-up fuel provider. 4.) Director of Maintenance or designee will report quarterly at the QAPI meetings the status of the fuel contracts to ensure there is always a back-up fuel company available.	
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/30/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The facility is a one-story building constructed in 1985. The facility has concrete flooring, wood frame roofing and bearing walls and brick exterior. The facility is noted to be a type V (111) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has a 125 KW (kilowatt) diesel generator that operates at 75% of load when tested. The facility has 94 occupied beds. The facility has eight smoke zones. .	K 000		
K 222	Egress Doors	K 222		3/21/23

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K 222 SS=E	Continued From page 4 CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be	K 222		

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K 222	Continued From page 5 permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure exit doors equipped with delayed-egress locking systems were operated properly and were provided with the required signs in accordance with NFPA 101 Life Safety Code (2012 edition) section 7.2.1.6.1.(4). This deficient practice had the potential to affect 12 residents in two smoke zones. Findings include: An observation of the service corridor exit door on 01/30/23 at 9:50 AM revealed the door was provided with a delayed-egress feature. The exit door lacked any type of delay egress sign	K 222	1.) No residents were affected by the deficient practice. 2.) There were 12 residents that had the potential to be affected by the deficient practice. 3.) On 1/30/23 all exit doors had signs on them "Push until alarm sounds. Door can be opened in 15 seconds." New permanent signs were ordered and placed on the doors once they were received in the facility. The second service corridor exit door that was intended to have a delayed-egress and did not was repaired to release after delay pending receival of the door guardian. The Director of Maintenance was provided education on	

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K 222	Continued From page 6 indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An observation of a second service corridor exit door on 01/30/23 at 9:55 AM near the cross-corridor doors revealed the door intended to be delayed-egress but did not release when the door was pushed to open. In addition, the door did not activate an alarm sequence or release within 15 seconds. The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An observation of the exit door near bedroom 164 on 01/30/23 at 10:30 AM revealed the door was provided with a delayed-egress feature. The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". There was glue on the door from where the original sign was removed. An observation of the exit door near bedroom 155 on 01/30/23 at 10:40 AM revealed the door was provided with a delayed-egress feature. The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". There was glue on the door from where the original sign was removed. An interview with the Maintenance Director at the time of each observation verified the condition of the exit doors.	K 222	the requirements for egress doors. 4.) The Director of Maintenance or designee will be responsible for conducting weekly audits x 1 month and then monthly thereafter. The audit reports will be reviewed at the monthly QAPI meeting to ensure compliance.	

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K 222	Continued From page 7 NJAC 8:39-31.2(e) .	K 222		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: . Based on observations, document review and interviews, the facility failed to ensure that two of 178 photo electric smoke detectors were greater than 36 inches from ceiling air diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 29.8.3.4.(6). This deficient practice had the potential to affect 17 residents. Findings include:	K 341	1.) No residents were affected by the deficient practice. 2.) There were 17 residents that had the potential to be affected by the deficient practice. 3.) The smoke detector in the employee break room and in the clean utility room were both moved to the next ceiling tile which made them within compliance of the 36" from a cooling diffuser. The Director of Maintenance was educated on the proper placement of the smoke	3/21/23

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K 341	Continued From page 8 An observation of a smoke detector in the staff breakroom on 01/30/23 at 9:40 AM revealed the smoke detector was 24 inches from a heating and cooling air diffuser. An observation of a clean utility room smoke detector on unit B on 01/30/23 at 10:25 AM revealed the smoke detector was 24 inches from a heating and cooling air diffuser. A review of the annual fire alarm inspection report dated 01/20/23 revealed the facility had 178 photo electric smoke detectors. An interview with the Maintenance Director at the time of each observation verified the measurements of the smoke detectors to the heating and cooling air diffusers. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 341	detectors from a cooling diffuser. Director of Maintenance or designee will conduct a monthly audit for 3 months and then annually thereafter to ensure all smoke detectors are located within the proper distance from a diffuser. 4.) All 178 smoke detectors are now in compliance. Director of Maintenance or designee will report monthly x 3 months at the QAPI meetings findings.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on observation, record review, and	K 345	1.) No residents were found to be affected by the deficient practice due to	3/21/23

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K 345	Continued From page 9 interview, the facility failed to complete a smoke detection sensitivity test for all 178 photo electric smoke detectors in accordance with NFPA 72 (2010 edition) National Fire Alarm and Signaling Code section 14.4.5.3.2. This deficient practice had the potential to affect all 94 residents. A review of fire safety records from the "Fire Alarm" folder revealed the most recent fire alarm inspection on 01/20/23 did not include a smoke detection sensitivity test. An observation on 01/30/23 from 9:40 AM to 11:30 AM revealed the facility has smoke detection in all corridors and bedrooms. The facility did not have a self-testing fire alarm system. An interview with the Maintenance Director on 01/30/23 at 2:00 PM revealed he does not have the test from the past two years and does not have a smoke detection sensitivity test for all 178 photo electric smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	the sprinkler system did not need to be activated. 2.) There were 94 residents that had the potential to be affected by the deficient practice. 3.) Our fire alarm testing vendor was contacted and the smoke detection sensitivity test was completed on 3/2/23. We scheduled the smoke detection sensitivity testing with the vendor for 2 times a year. Education was provided to the Director of Maintenance on the requirements for smoke and fire alarms testing. The Director of Maintenance or designee will ensure that the required smoke detection sensitivity tests are completed 2 times a year. The Director of Maintenance will inform the Administrator of the scheduled visits. 4.) Director of Maintenance will submit the reports to the monthly QAPI committee for review.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		4/1/23

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K 353	Continued From page 10 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: . Based on observations, record review and interviews, the facility failed to ensure the sprinkler system was maintained in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems (2011 edition) sections 4.3.1, 5.2.1.1.1 and 5.4.2.4. This deficient practice had the potential to affect all 94 residents. Findings include: An observation on 01/30/23 at 11:25 AM revealed the canopy near bedroom 109 had two sprinkler heads that were discolored blue and not the original color. An interview with the Maintenance Director at the time of the observation verified the discoloration of the sprinkler heads. An observation of the dry sprinkler air compressor on 01/30/23 at 11:45 AM revealed the device was new and was installed six months earlier. The device was free standing near the dry system.	K 353	1.) No residents were affected by the deficient practice. 2.) There were 94 residents that had the potential to be affected by the deficient practice. 3.) Education was provided to the Director of Maintenance on the NFPA 25 Standard for the inspection, testing, and maintenance of water based fire protection systems. a. The 2 discolored sprinkler heads under the canopy will be replaced. b. A tagout was installed on the dry sprinkler air compressor switch and a new compressor log was initiated and will be completed on a weekly basis. The tagout will allow the technicians to work safely on the system and will not allow anyone else access. The Director of Maintenance or designee will conduct weekly sprinkler head audits for 1 month and then monthly for 2 months to ensure compliance. Our fire protection company will conduct their inspections and provide their reports to ensure compliance. 4.) The audits and reports will be	

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K 353	Continued From page 11 Interview with the Maintenance Director at the time of the observation stated he had been checking the device but did not have records. He stated he would keep a log of records for maintaining the dry sprinkler air compressor. He was unable to produce records/specifications or a manufacturer's recommendations for maintaining the air compressor. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25 .	K 353	submitted and reviewed at the monthly QAPI meetings.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		3/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING **01** B. WING _____	C **01/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	**3809 BAYSHORE ROAD** **NORTH CAPE MAY, NJ 08204**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 12 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure corridor doors latched into the frame without impediment in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.3. This deficient practice had the potential to affect 26 residents in three smoke compartments. Findings include: An observation on 01/30/23 at 9:40 AM revealed the break room door in the service corridor was propped open with a large garbage can. When attempts were made to close the door, the garbage can had to be removed to allow the door to close and latch. An observation on 01/30/23 at 10:30 AM revealed the door to bedroom 162 was equipped with a device at the top of the door to hang seasonal items. The device impeded the door from closing	K 363	1.) No residents were affected by the deficient practice. 2.) There were 26 residents that had the potential to be affected by the deficient practice. 3.) a. The trashcan was immediately removed and moved to the other side of the breakroom. A sign was placed on the door not to prop open the door. Staff were in-serviced on not blocking the door. b. Room 162 had the device removed from the door. An audit of all doors was conducted, Staff were in-serviced on not having any item impede the closing of doors. 3.) Director of Maintenance or designee will conduct random weekly audits x 4 weeks and monthly x2 months. Families will be notified during the admission process what seasonal decorations are permitted. 4.) Director of Maintenance will submit	

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PELICAN POINTE POST ACUTE NURSING & REHABILITATION	**3809 BAYSHORE ROAD** **NORTH CAPE MAY, NJ 08204**

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K 363	Continued From page 13 and had to be removed to allow the door to close and latch. An interview with the Maintenance Director at the time of each observation verified the problems with each door. NJAC 8:39-31.1(c), 31.2(e) .	K 363	audits to the monthly QAPI committee for review.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) sections 8.5.2.1 and 8.5.6.2. This deficient practice had the potential affect all 94 residents.	K 372	1.) There were no residents affected by this deficient practice. 2.) There were 94 residents that had the potential to be affected by the deficient practice. 3.) The areas that had fire foam had the foam removed and replaced with fire barrier sealant. All other areas were checked and were in compliance. Education was provided to the Director of	3/21/23

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	315508	A. BUILDING **01** B. WING _____	C **01/30/2023**

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PELICAN POINTE POST ACUTE NURSING & REHABILITATION	**3809 BAYSHORE ROAD** **NORTH CAPE MAY, NJ 08204**

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K 372	Continued From page 14 Findings include: An observation of the smoke barrier wall near bedroom 122 on 01/30/23 at 11:35 AM revealed an unsealed hole measuring eight inches high by four inches wide with one and one quarter inch silver conduit running through it. An observation on 1/30/23 from 11:30 AM to 11:45 AM revealed the facility used non-fire rated foam to seal seams and holes at the smoke wall near activities, at smoke wall seven, at a smoke wall nine, at a smoke wall near bedroom 134, smoke wall at 14 or bedroom 146, smoke wall at 16 or bedroom 158 and smoke wall 18 at the main dining area. In an interview with the Maintenance Director at the time of each observation, he stated the foam was used because the can read that the fire foam would prevent the passage of smoke and fire and he also verified the hole in the smoke wall. NJAC 8:39-31.1(c), 31.2(e) .	K 372	Maintenance the fire requirements for smoke penetration. The Director of Maintenance or designee will continue to monitor for any holes that may allow for smoke penetration and seal with fire barrier sealant. Director of Maintenance or designee will complete weekly audits x 1 month and monthly thereafter for 3 months to ensure compliance. Any issues will be immediately corrected. 4.) The Director of Maintenance will submit findings at the monthly QAPI meetings.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the	K 741		3/2/23

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K 741	Continued From page 15 international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: . Based on observations, interview and record review, the facility failed to ensure smoking regulations were enforced by failing to provide a metal container with a self-closing lid to empty ashtrays into in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.7.4. This deficient practice had the potential to affect 26 smokers. Findings include: An observation of the smoking area on the patio off the conference room on 01/30/23 at 11:06 AM revealed there was no metal self-closing container in which to empty the ash trays. An interview with the facility Administrator on 01/30/23 at 11:15 AM verified the lack of a	K 741	1.) No residents were affected by the deficient practice 2.) There were 26 smokers that had the potential to be affected by the deficient practice. 3.) New metal self-closing ashtrays and a metal container were purchased for the smoking area. The smoking policy was revised to include the extinguishing of cigarette butts and the disposal of the butts. In-servicing was provided to the staff and the residents regarding the revised policy. Activities will monitor smokers for compliance. NHA or designee will conduct random weekly audits x 1 month and monthly thereafter for 2 months. Any non-compliance issues will be immediately address at the time of the occurrence.	

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K 741	Continued From page 16 self-closing metal container. In addition, it was observed with the Administrator, cigarette butts too numerous to count in a 33 gallon garbage container in the smoking area. The garbage container was noted to contain leaves, packages and wrappers as well as used cigarette butts. A review of the facility policy dated 11/22 titled "Pelican Pointe Smoking Policy" revealed the policy lacked references to safety while smoking such as extinguishing cigarettes in ash trays only, disposing of all ashes and cigarette butts when finished smoking, and how and when and where to dispose of such cigarette butts. NJAC 8:39-31.2(e), 31.6(e)	K 741	4.) NHA will review the findings at the monthly QAPI meetings.	
K 916 SS=F	. Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: . Based on observation, interview, and record review, the facility failed to ensure the remote annunciator was located in an observable area	K 916	1.) No residents were affected by the deficient practice. 2.) There were 94 residents that had the potential to be affected by the deficient	3/21/23

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K 916	Continued From page 17 accordance with NFPA 99 (2012 edition) section 6.4.1.1.17.1 This deficient practice had the potential to affect all 94 residents. Findings include: An observation of the remote annunciator panel on 01/30/23 at 10:40 AM revealed the generator remote annunciator panel was found in the service corridor. The service corridor does was not an observable area. Staff work in the area daily from 5:00 AM to 11:00 PM in laundry. Staff are not present in the area after 11:00 PM daily. An interview with the Maintenance Director at the time of the observation indicated the device the device has always been at that location. A review of the generator contractor report dated 01/03/23 revealed no reference to the remote annunciator panel in the untitled binder provided by the Maintenance Director. NJAC 8:39-31.2(e) NFPA 99, 110	K 916	practice. 3.) The annunciator panel was relocated to the A-wing nursing station which is an observable area. Director of Maintenance or designee will conduct weekly audits for 1 month and monthly for 2 months to ensure compliance. Staff were in-serviced on monitoring of the panel. The annunciator panel needed to be re-wired by the Maintenance Director and will not be moved to another location. 4.) Director of Maintenance will report findings at the monthly QAPI meetings to ensure compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		2/15/23

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K 918	Continued From page 18 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to ensure the 125 KW (kilowatt) generator was inspected weekly in accordance with NFPA 110 (2010 edition) Standard for Emergency and Standby Power Systems section 8.4.1. This deficient practice had the potential to affect all 94 residents. Findings include: A review of the facility generator logs for the 125 KW generator revealed no weekly generator	K 918	1.) No residents were affected by the deficient practice. 2.) All residents had the potential to be affected by the deficient practice. 3.) Director of Maintenance in-serviced 3 designated Administrative staff on the proper procedure for how to conduct the weekly generator testing. 4.) Director of Maintenance will submit his monthly generator testing reports to the QAPI to ensure compliance.	

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K 918	Continued From page 19 inspections on 10/12/22 and between 05/08/22 and 05/26/22. An interview with the Maintenance Director on 01/30/23 at 12:15 PM indicated he was on vacation in May 2022 and does not know what happened in October of 2022. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110 .	K 918		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315508 Y1	A. Building 01 - VICTORIA MANOR B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	03/21/2023	LSC K0341	03/21/2023	LSC K0345	03/21/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	04/01/2023	LSC K0363	03/21/2023	LSC K0372	03/21/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0741	03/02/2023	LSC K0916	03/21/2023	LSC K0918	02/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315508 Y1	A. Building B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0041	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/21/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction		Correction
Reg. #	Completed	Reg. #	Completed		Completed
LSC		LSC		LSC	

Ex.Order 26.4(b)(1)

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/30/2023	☐ YES ☐ NO